THE EASTERN CARIBBEAN SUPREME COURT
SAINT LUCIA

IN THE HIGH COURT OF JUSTICE
(Civil)

SLUHCV2014/0610

BETWEEN:

1. EARWIN CURTON MASON
2. FEDILIA PAUL
Tutors acting as Next Friends for the Minor and Dependant Charlize Anna Mason
3. PATRICIA ALFRED
as the Representative Party of the Estate of Nadia Paul-Mason

Claimants

and

1. DR. LEONARD SURAGE
2. THE ATTORNEY GENERAL

Defendants

Before:
The Hon. Mde. Justice Kimberly Cenac-Phulgence High Court Judge

Appearances:
Mr. Gerard Williams of Counsel for the Claimant
Mrs. Karen Barnard with Ms. Kozel Creese of Counsel for the Defendant

Present:
Second and Third Claimants

2018: March 21;
November 28.

JUDGMENT

[1] CENAC-PHULGENCE J: This is a claim in medical negligence arising out of the death of Nadia Paul-Mason ("Ms. Mason") on or about 7th March 2014. The claimants are Mr. Earwin Curtin Mason and Ms. Fidelia Paul, the Tutors, acting as Next Friends for Ms. Mason's daughter who is a minor and dependant of Ms. Mason,

and Ms. Patricia Paul-Alfred, the representative of her estate. The claim is brought against the Attorney General, in its capacity as legal representative of the Crown, Ms. Mason having been under the care of the Victoria Hospital **("the Hospital")** at the time of her death. By order of the Court dated 7th December 2017, Dr. Leonard Surage was removed as a party to the proceedings and the claim against him discontinued and accordingly dismissed. The matter was ordered to proceed to trial against the Attorney General as the sole defendant.

Background

[2] The relevant facts of this case are that Ms. Mason was, at the material time, a forty-one (41) year old female who presented to the Hospital on or about 16th January 2014, experiencing pleuritic chest pain, progressive shortness of breath, exertional dyspnea and associated chills and palpitations. She gave a history of longstanding hypertension for which she was on medication and large uterine fibroids for many years.

[3] On that same day, Ms. Mason was admitted to the Acute Medical Unit of the Hospital, and on clinical examination, was found to be suffering from several medical conditions, namely acute pulmonary embolism, swelling of the left leg as a result of deep vein thrombosis, uncontrolled hypertension, congestive cardiac failure, pneumonitis/ pneumonia of the lower lobes, and large uterine fibroids.

[4] On or about 17th January 2014, Ms. Mason, having developed acute respiratory failure, was admitted to the Intensive Care Unit (ICU) for mechanical ventilation via insertion of an endotracheal tube[1], and further management.

[5] On or about 22nd January 2014, while in the ICU and on the ventilator, Ms. Mason suffered cardio-respiratory arrest, which lasted over five (5) minutes, from which she was resuscitated. As a result of the cardio-respiratory arrest, Ms. Mason

---

[1] As explained by Dr. Martin Didier at trial, an endotracheal tube is 'something that is placed through the mouth into the throat into the trachea which will enable the patient to be attached to the mechanical ventilator. He said further that this tube is not left for long. It is replaced by the tracheostomy tube.

subsequently developed seizures which were thought to be due to hypoxic brain damage occurring during the period of cardiac arrest. In addition, subsequent to the cardio-respiratory arrest, Ms. Mason remained in a deep comatose state and never regained consciousness.

[6] On 11th February 2014, a tracheostomy tube[2] and percutaneous endoscopic gastronomy (PEG) tube[3] were inserted into Ms. Mason to assist in her long term supportive care, in light of her multiple serious medical issues and poor prognosis.

[7] On 15th February 2014, Ms. Mason was admitted to the general medical ward, with the following medical problems – hypoxic brain damage with a comatose state; post cardiac arrest, extensive pulmonary embolism; deep vein thrombosis of the left leg; tracheostomy in situ; vena caval filter (IVC) in situ; pneumonia. She remained on the general medical ward until 7th March 2014, the date of her death. Prior to her death, her relatives had been made aware of her poor state and were preparing for home care with the help and advice of the medical team at the Hospital.

Claimant's Case

[8] **The claimant's case** is that the defendant was at all material times responsible for the administration and operation of the Hospital, pursuant to the Public Hospitals (Management) Act[4] which provided medical, specialist and other services. The claimants claim that the defendant therefore owed a duty of care to Ms. Mason including to ensure that reasonable care was at all times taken in providing medical, nursing and other care to Ms. Mason and that there was a safe system of health care at the Hospital.

---

[2] As explained by Dr. Martin Didier at trial, the tracheostomy tube is 'a tube inserted into the trachea in order to assist and improve the ventilation or oxygen level in the blood which goes to all the vital organs.' Dr. Didier explained that the tracheostomy tube replaced the endotracheal tube.

[3] As explained by Dr. Martin Didier at trial, the PEG tube 'Percutaneous Gastrostomy Tube' is 'a feeding tube inserted through the skin into the stomach.'

[4] Cap 11.03 of the Revised Laws of Saint Lucia 2008.

[9] The claimants, in their statement of claim aver that the death of Ms. Mason was caused by the failure of the defendant to provide adequate reasonable care to Ms. Mason at all times, given the severity of her condition. They say that she was gravely ill and required the attendance of medical personnel to frequently clean and clear the tracheostomy tube through which she breathed of all mucus or other material to allow for free passage of air. They aver that Ms. Mason died of respiratory failure due to an occluded tracheostomy tube.

[10] The particulars of negligence as pleaded in their statement of claim are as follows:

i. Failing to monitor Ms. Mason's condition to ensure that she was breathing efficiently and comfortably at all times through the tracheostomy tube;
ii. Failing to recognise that Ms. Mason's condition indicated that Ms. Mason was experiencing difficulty in breathing through the tracheostomy tube;
iii. Failing to properly supervise the attending medical, nursing and other staff of the Hospital to ensure that Ms. Mason was properly cared for as it related to her breathing;
iv. Failing to clean or direct the cleaning of the tracheostomy tube when it became necessary;
v. Failing to adequately clean or at all the tracheostomy tube when it was required to ensure that Ms. Mason was breathing comfortably and efficiently; and
vi. In all the circumstances failing to provide a safe system for the provision of health care.

[11] The claimants claim that as a result they suffered loss and damage for which they are claiming medical and funeral expenses in the sum of $21,000.00 and for the care and maintenance of Ms. Mason's minor, dependant daughter, in particular as it relates to her health and schooling until she attains the age of majority. The claimants' claim special damages, general damages, interest and costs.

Defendant's Case

[12] **The defendant's case is that** Ms. Mason was gravely ill on or about 16th January 2014 when she was admitted to the Hospital and at all material times up to and prior to her death or occlusion of the tracheostomy tube. The defendant contends that Ms. Mason was consistently monitored, but that pneumonia as well as a pulmonary embolism compromised her breathing, irrespective of the insertion of the tracheostomy tube. The defendant contends that the tracheostomy tube was cleaned regularly, and the oxygen saturation levels continued to be satisfactory up to just prior to her death.

[13] The defendant avers that the cleaning of the tracheostomy tube, which was the duty of the nursing staff, was carried out diligently, applying the standard measures and procedures in maintaining the tube. The defendant avers that neither it nor any of its staff at the Hospital failed to provide a safe system of health care as alleged, or at all. The defendant says Ms. Mason was attended by doctors and staff at the Hospital and administered a standard course of treatment for her various diagnoses. The defendant denies that the death of Ms. Mason was caused by a breach of duty of the defendant and/or any servants or agents of the Crown as alleged, or at all and contend that the occluded tracheostomy tube is most likely to have been caused by a sudden event due to the circumstances of its occurrence.

[14] The defendant contends that (a) there was an inherent risk in the treatment of Ms. Mason that the tracheostomy tube could become suddenly blocked despite the exercise of reasonable care and skill; (b) the care given Ms. Mason accorded with the standard practice and procedure; and (c) Ms. Mason**'s death occurred despite** appropriate treatment administered for her various medical conditions. Alternatively, Ms. Mason carried a high mortality risk due to her myriad medical problems prior to the time of her death, including unconsciousness; and because her prognosis was poor and her condition not likely to improve. If it is determined that the defendant or its servants or agents were in breach of duty, which is denied, any loss suffered

by the claimants as a result would be limited by Ms. Mason's pre-existing state and condition.

Issues

[15] The issues to be determined are as follows:

i. Whether the defendant owed a duty of care to Ms. Mason?

ii. If the defendant owed Ms. Mason a duty of care, whether the defendant breached that duty?

iii. If there was a breach of duty of care, whether such breach caused Ms. Mason's death?

iv. Whether Ms. Mason's death was foreseeable as a result of any such breach of duty of care?

v. If the defendant is liable in negligence, whether the claimants are entitled to damages, including special damages?

The Law

Duty of Care

[16] The claimants cited the cases X (minors) v Bedforsdshire County Council[5] and Gemyma Norville v The Attorney General[6] as authority for the fact that hospitals owe a primary, non-delegable duty of care, which can be both direct and vicarious, to its patients to provide proper treatment.

[17] In Gemyma Norville, the court cited Lord Browne-Wilkinson in Wilsher v Essex Area Health Authority,[7] where he stated:

> "…a health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient."[8]

[5] (1995) 2 AC 633

[6] SLUHCV2004/0362 (See paragraphs 62-69.)

[7] (1986) 3 AER 801.

[8] At paragraph 64

[18] In X (Minors) v Bedfordshire County Council, Lord Browne-Wilkinson again had this to say:

> "The position can be illustrated by reference to the hospital cases. It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital (I express no view as to the extent of that duty). They are liable for the negligent acts of a member of the hospital staff which constitute a breach of that duty, whether or not the member of the staff is himself in breach of a separate duty of care owed by him to the plaintiff".[9]

It is a well-established principle that hospitals and those conducting hospitals are under a duty of care to its patients and may be liable in negligence for breach of that duty.

[19] In the case of R v Bateman,[10] this was the Court's assessment of the duty of care owed by a medical practitioner

> "If a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward. It is for the judge to direct the jury what standard to apply and for the jury to say whether that standard has been reached. The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned. If the patient's death has been caused by the defendant's indolence or carelessness, it will not avail to show that he had sufficient knowledge; nor will it avail to prove that he was diligent in attendance if the patient has been killed by his gross ignorance and unskilfulness. No further observation need be made with regard to cases where the death is alleged to have been caused by indolence or carelessness. As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man, As regards cases of alleged

[9] At page 740
[10] (1925) 94 L.J.K.B. 791 at 794; [1925] All ER Rep 45 at 48-49.

recklessness, juries are likely to distinguish between the qualified and the unqualified man. There may be recklessness in undertaking the treatment and recklessness in the conduct of it. It is, no doubt, conceivable that a qualified man may be held liable for recklessly undertaking a case which he knew, or should have known, to be beyond his powers, or for making his patient the subject of reckless experiment. Such cases are likely to be rare. In the case of the quack, where the treatment has been proved to be incompetent and to have caused the patient's death, juries are not likely to hesitate in finding liability on the ground that the defendant undertook, and continued to treat, a case involving the gravest risk to his patient, when he knew he was not competent to deal with it, or would have known if he had paid any proper regard to the life and safety of his patient."

Standard of Care

[20] The defendant directed the court's attention to the case of Bolam v Friern Hospital Management Committee[11], the *locus classicus* as to the requisite standard of care and skill to be discharged by medical practitioners in exercise of their duties. McNair J stated the standard of care thus:

> "But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is... the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art... A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."

Standard and Burden of Proof

[21] The defendant correctly states that the general rule in civil cases is that the party who asserts must prove. The claimants therefore bear the legal burden of proving the elements of the claim of medical negligence against the defendant, being that a duty of care was owed by the defendant to the claimants; the defendant breached such duty in that the defendant caused or materially caused the deceased's death; her death was foreseeable as a result of the breach of duty; and the loss suffered

[11] (1957) 1 WLR 582.

as a consequence. The defendant also correctly states that the required standard of proof to be met by the claimants is on a balance of probabilities.

Analysis

i. Whether the defendant owed a duty of care to Ms. Mason?

[22] There is no dispute that Ms. Mason was under the care of and receiving treatment for her medical conditions from the Hospital from 16th January 2014 to 7th March 2014. It is acknowledged by the parties that the defendant therefore owed Ms. Mason a duty of care to exercise reasonable care and skill in treating her at the Hospital. What is disputed in this case is the cause of her death and whether it is attributable to a breach by the defendant of its duty of care.

ii. Whether the defendant breached its duty of care to Ms. Mason?

[23] The claimants' called one witness, Patricia Paul-Alfred ("Ms. Paul-Alfred"), Ms. Mason's sister. The other witness for the claimant, Dr. Stephen King did not attend the trial and there was no indication from Counsel for the claimant that Dr. King would not have been available prior to the trial. In any event, the cause of death which would have been found by Dr. King on the post mortem is as stated on the death certificate relating to Ms. Mason and there is no dispute as to the cause of death.

[24] Ms. Paul-Alfred gave evidence that in January 2014, family members took Ms. Mason to the Accident and Emergency Department of the Hospital, as Ms. Mason had been complaining of breathing issues which had become serious. The following day, it was discovered that Ms. Mason had a blood clot in her lungs which posed a serious risk to her health; that Ms. Mason was placed into an induced coma with mechanical devices connected to her to carry out vital bodily functions; that as she understood, the coma was to prevent or minimize the risk of injury or possibly death by the clot moving to another organ; that Ms. Mason began to come out of the coma shortly after and communicate by small audible sounds and signs with her hands;

that later tests revealed that the clot was gone but that she had suffered brain damage; and that nothing else could be done for her.

[25] Ms. Paul-Alfred, the claimant's only witness was not an expert witness. As the claimants' counsel, Mr. Gerard Williams ("Mr. Williams") points out in closing submissions, her evidence was not of a medical nature and mainly contained her observations at the bedside of Ms. Mason. She was not in a position to provide evidence as to any direct act or omission of the defendant which was the cause of Ms. Mason's death. Her evidence in this regard can therefore be given no weight.

[26] The claimants essentially relied upon the medical evidence of the witnesses called by the defendant in their closing submissions.

[27] Mr. Williams noted that the Hospital Record of Dr. Martin Didier (Dr. Didier) stated that the treatment plan was to keep Ms. Mason sedated/paralysed. Mr. Williams relied upon statements of Dr. Didier in cross examination to the effect that when mechanical lung support is given, the patient must be paralysed in order to put in the tube – a drug induced sedation, which was done to Ms. Mason. Drugs were given to paralyse her; the objective being to keep her as quiet as possible. Mr. Williams also placed significance on Dr. Didier's explanation in cross examination that sedative drugs have a different half-life – it peaks within a period and then the level falls. At the point when the drug wears off, the patient's level of consciousness would be lighter rather than deeper. Dr. Didier further said that an ICU nurse would be responsible for ensuring that the patient is adequately sedated based on parameters used.

[28] Mr. Williams in his closing submissions relied on Dr. Didier's statement that when Ms. Mason first came to the ICU, she did not have brain damage and the reason for Ms. Mason going to the ICU was for respiratory lung support. He also relied on the evidence of Dr. Leonard Surage ("Dr. Surage") that Ms. Mason suffered brain damage from the cardiac arrest and that the difficulty in management of the tube in

Ms. Mason's case was related to the following conditions: Ms. Mason was unconscious with Glasgow Coma Scale of 4/15 and had no neurological response to cough, or no cough reflex to protect the lungs from aspiration. Mr. Williams further relied on Dr. Surage's evidence that Ms. Mason was gravely ill having suffered from multiple medical conditions including being in a coma from hypoxic brain damage and epilepsy, which was a result of the brain damage.

[29] Based on this evidence, in his submissions, Mr. Williams in his closing submissions made several assertions as to the cause of Ms. Mason's death. He asserted that Ms. Mason had been sedated due to the discomfort of having the endotracheal tube inserted into her throat and that this measure prevented her from removing the tube, which was her only means of breathing. He asserted that sedation medicine, once given to a patient peaks, then falls and that it was the duty of the medical staff to keep the patient sedated to prevent removal of the tube. He said that Ms. Mason did in fact remove the tube on 22nd January 2014 while in the care of the defendant at the ICU and was discovered by the nurses cyanosed and without a pulse, having suffered cardiac arrest. She was resuscitated, but regrettably had already suffered hypoxic brain damage as a result of lack of oxygen. He highlights evidence that a person in Ms. Mason's condition would succumb in less than three (3) minutes and that in Ms. Mason's case the period of cardiac arrest was more than five (5) minutes because some patient's take longer to recover.

[30] He submitted that this was one of the two instances of the defendant's breach of their duty of care to Ms. Mason which amounts to an admission of negligence. He argued that it was the Hospital staff's duty to ensure that Ms. Mason was properly sedated at all times to prevent her from removing the tube which was her only source of ventilation. It was also the duty of the Hospital staff to ensure that if, for any reason, Ms. Mason's condition was threatened through events which were under their control that they were available to immediately intervene to correct the situation. He says that sufficient time passed without Ms. Mason having the benefit of the defendant's care which led to her suffering cardiac arrest ultimately leading

to her hypoxic brain damage. He argued that the claimants do not have to go beyond this point to establish that death and consequential loss was the result of **the defendant's breach. It is sufficient to establish that Ms. Masons' brain damage** eventually led to her declining condition and eventual death.

[31] The Court notes that Mr. Williams raises the removal of the endotracheal tube and consequent cardiac arrest and brain damage **as the cause of Ms. Mason's death** for the first time during his closing submissions. The Court is of the view that is impermissible. Removal of the endotracheal tube and consequent cardiac arrest ought to have been pleaded as a **cause of death in the claimant's** statement of claim.

[32] Mr. Williams in closing arguments **says that the claimants' initial** allegation focused **on the tracheostomy tube which the claimants' alleged was blocked. However, he says that the claimants' focus was redirected to the endotracheal tube, which from** the bedside notes, was the initiating factor ultimately leading to Ms. Mason suffering cardiac arrest, brain damage and ultimately her death through respiratory failure; **and that the claimants' pleadings in specific and general terms are sufficient to cover** even this shift in focus while maintaining the claim in negligence.

[33] The Court disagrees. The law requires that pleadings in a claim in negligence indicate the duty of care owed by the defendant, the facts from which the duty flowed and how the breach of that duty occurred. The particulars of a claim must be adequate to enable the opposing party to understand the nature of the claim, the facts on which it is based and the remedy being sought[12]. In particular, rule 8.7(1) of the Civil Procedure Rules 2000 **stipulates that "th**e claimant must include in the claim form or in the statement of claim, a statement of <u>all the facts</u> on which the claimant relies." (emphasis added)

[12] See CPR8.6 (1) and 8.7 (1) & (2).

[34] In the case of Shankiell Myland v Commissioner of Police et al[13], Ellis J said the following:

> "Litigation proceeds on the basis that the court is a court of pleadings. They are critical in that they give fair notice of the case that has to be met, so that the opposing party may direct its evidence to the issues disclosed and they assist the court in adjudicating on the allegations made by the litigants. Not only should they define the issue(s) between litigants with clarity and precision, but they also serve as a record of the issues involved in the action which can (if necessary) be referred to at a later date."[14]

[35] Ellis J further said:

> "The Court cannot accept that in these circumstances it is appropriate for a claimant to ignore the requirements set out under the CPR and to seek to litigate an issue which has not been raised in his pleadings, thus taking the opposite party completely by surprise."[15]

[36] The claimants have not complied with CPR 8.6 and 8.7. In their Particulars of Negligence set out above, the claimant's do not mention any negligent act or omission on the part of the defendant in relation to the endotracheal tube and consequent cardiac arrest. The Particulars of Negligence focus almost solely on the tracheostomy tube. This omission is even more glaring, considering that the claimants specifically state in their statement of claim:

> "<u>For the avoidance of doubt, the claimants' case as to causation will be</u> that Ms. Mason who was fitted with a tracheostomy tube required constant attention as an in-patient and who was not capable of clearing and cleaning the said tube of mucus or other material. The occurrence of mucus within the tube was a natural event which required constant cleaning through frequent and adequate suction or the removal and cleaning of the item. That it was a foreseeable event that if the patient could not breathe that death would be imminent." (emphasis added)

[37] In any event, the Court finds that Mr. Williams' assertions in his closing submissions that the cause of death was the removal of the endotracheal tube and subsequent cardiac arrest are merely his conclusions on the medical evidence of the defendant's

[13] GDAHCV2012/0045, delivered 9th May 2014, (unreported).
[14] At paragraph 37.
[15] At paragraph 4.

witnesses. In the absence of expert medical testimony declaring these conclusions, the Court is of the view that Mr. Williams is not in a position to make such pronouncements, and the Court cannot therefore accept them.

[38] Moreover, Mr. Williams' assertions on closing submissions are in direct contrast to the uncontroverted evidence and conclusions of the very expert witnesses whom the claimants rely and whose evidence must necessarily be preferred.

[39] Dr. Surage in his evidence says:

> "It is my opinion in our setting, with the facilities and resources at our disposal, Mrs. Mason received standard medical care. Her demise was attributable to the fact that she was critically ill, suffering from multiple medical conditions from which she was unlikely to improve."

[40] This is corroborated by Dr. Didier's evidence where he concludes:

> "Her diagnoses and clinical management throughout her period of hospitalization at Victoria Hospital were appropriate and standard in the medical practice."

[41] In relation to the cardio-respiratory arrest in particular, which the claimants now claim is the cause of death, Dr. Didier states very clearly that "the respiratory failure and cardiac arrest was considered to be a complication of her massive pulmonary embolism."

[42] In relation to the tracheostomy tube, Dr. Didier's evidence was that

> "Ms. Mason was found to have an occluded tracheostomy tube with soft mucus probably from secretions of her lung infection/pneumonia. This does not constitute malpractice or neglect by the Ear Nose and Throat surgeon."

[43] For these reasons, the Court can accord little weight if any to the assertions of Mr. Williams in his closing submissions as it relates to the endotracheal tube being the initiating factor ultimately leading to Ms. Mason suffering cardiac arrest, brain damage and ultimately her death.

[44] Further, the Court accepts the defendant's witnesses' evidence that the tracheostomy tube was cleared and cleaned through suctioning by the staff at the Hospital as required, in particular by the attending nurse, Ms. Mina Phillip ("Nurse Phillip") on 6th and 7th March 2014.

[45] Dr. Surage's evidence is that a tracheostomy tube can become blocked when mucus is dry due to lack of humidification in which event mucus crusting then develops which compromises the tube function. The Court accepts the defendant's evidence which shows that the patency of the tube was not compromised and that the mucus suctioned by Nurse Phillip was thin white mucus and not dried crusted mucus, suggestive of lack of humidification. The Court accepts that the secretions suctioned on the last shift were not copious and were described as clear, therefore providing no indication that Ms. Mason's breathing was compromised. The Court further accepts that there were no other indicators which would have alerted the attending nurses that the tracheostomy tube was blocked or that Ms. Mason was experiencing difficulty, such as increased work of breathing, abnormal breath sounds, increased heart rate, or decreased SpO2 levels (level of oxygen in a patient's blood). The Court accepts that any mucus would have likely been sudden onset.

[46] The Court also accepts the defendant's submission that the evidence bears out the frequency of assessment of Ms. Mason, at times, fifteen minutes to half an hour intervals. Leading up to her death, at 1:54 a.m. Ms. Mason was assessed. At 2:06 a.m., she was reassessed and her SpO2 was 100%. Again at 2:22 a.m., she was monitored and her condition remained the same. Again at 2:43 a.m., she was reassessed, however found not to be responding. At 2:45 a.m., the Doctor on call was called. The Court therefore accepts the defendant's submission that the nurse on duty suctioned as necessary, but that even with the exercise of reasonable care and skill, blocking of the tracheostomy tube is a complication which could occur. This is supported by the evidence of Dr. Surage and Nurse Phillip. The evidence of Dr. Dawit Kabiye was that patients with tracheostomy tubes are to be assessed for

signs of respiratory distress, one of these being decreases in SpO2 levels which may indicate an obstruction of the airway. The evidence of the defendant through Nurse Phillip clearly indicates that at the time of the assessments carried out on Ms. Mason, her oxygen levels did not raise any cause for concern as they remained at 100% until the last assessment. As Dr. Surage said in his evidence on cross-examination, all parameters remained the same up until fifteen minutes before the last assessment and therefore there was no cause for alarm.

[47] The Court therefore finds that the claimants have failed to establish on a balance of probabilities that Ms. Mason's death was caused or materially contributed to by negligence on the part of the defendant's servants or agents. The Court further accepts the defendant's case that the medical and nursing professionals performed their duties with the necessary care and skill that was required of them. The Court finds nothing in the evidence to show any negligence on the part of the defendant's servants or agents causing or contributing to the death of Ms. Mason. There being no breach of the defendant's duty of care towards Ms. Mason, it is no longer necessary to consider the other issues.

[48] The Court however takes the opportunity, for completeness, to address other matters which arose on the claim.

[49] The first is Ms. Paul-Alfred's evidence as to what she describes as the degrading treatment of her sister, in that "she (Ms. Mason) was dressed in a transparent surgical gown with her bed next to the doorway... as if she was on display for the world to see". However, under cross-examination, it was suggested to Ms. Paul-Alfred that the surgical gown is one that is provided if Ms. Mason is out of her own garment, to which she responded that Ms. Mason wore the surgical gown in the ICU but that on the ward she could have had her own clothes and she did wear her own clothes. When it was suggested to Ms. Paul-Alfred that one would have to go through a door, then through a corridor and then another door to get to Ms. Mason's room, Ms. Paul-Alfred replied that she was not at the time paying attention to this.

She accepted that Ms. Mason's bed was positioned closest to the nurse's station and that persons could not just walk into the Hospital; they would have to be allowed.

[50] In addressing the claimants' allegation of the degrading treatment meted out to Ms. Mason, the Court finds that the evidence does not disclose degrading treatment. In any event, such treatment, even if made out, would not go to the issue of proving negligence on the part of the defendant.

[51] Second, the defendant, in its submissions, urged the Court to dismiss the claim of the first and second claimants as a consequence of their failure to provide evidence as to their capacity as tutors acting as Next Friend for Ms. Mason's daughter. The Court is not minded to dismiss the claim for that reason. CPR 8.7(3) provides that "the Claim Form or the Statement of Claim must identify any document which the claimant considers to be necessary to his or her case." To the extent that the claimants stated in the claim form that Earwin Curton Mason and Fedilia Paul "were appointed by Order of the Court dated the 17th August 2014 to act jointly as Tutors for the Minor Charlize Anna Mason, a dependant of Nadia Paul-Mason", the first and second claimants have complied with this Rule, though it may have been prudent to exhibit a copy of the Order in support. Furthermore, the defendant, if necessary, could have made a formal request for further and better particulars as permitted under Part 34 of the CPR to satisfy itself and the Court of the claimants' capacity. In any event, this is a matter which ought properly to have been raised at case management or at the trial itself rather than in submissions. The Court will therefore not entertain such request at this point.

[52] The third matter which the Court notes is that Ms. Paul-Alfred gave evidence that Ms. Mason was an entrepreneur who owned her own photo studio, which did business mainly with hotels and other special events and that Ms. Mason provided everything for her daughter. In her evidence, Ms. Paul-Alfred sets out the costs of Ms. Mason's daughter's expenses which included sums in respect of food, transportation to and from school, school uniforms, books, bag, clothing and medical

care for seizures including medication and physician visits, for which damages are claimed. However, the claimants provided no documentary evidence to support the expenses and figures stated by Ms. Paul-Alfred; neither was evidence provided in support of Ms. **Mason's business**. The Court finds this to be unsatisfactory as such claim ought to be supported by documentary evidence from which the Court could make an assessment as to any quantum of damages to which the claimants, if successful, would have been entitled.

Conclusion

[53] In light of the foregoing discussion, the Court finds that the claimants have not proved their case on a balance of probabilities. In medical negligence claims, it is for the claimant to show that the standard of care meted out to the patient fell below the standard reasonably to be expected of a competent medical practitioner. This must be assessed by some objective evidence from an independent medical practitioner qualified to assist with this type of assessment. The fact that a claimant is unhappy with treatment or thinks that a certain procedure ought to have been adopted or that in his opinion, X was the cause of death, does not mean that a medical practitioner was negligent or in this case that the Hospital through its agents was negligent.

Order

[54] It is hereby ordered that:-

1. The claim against the defendant for negligence is dismissed.
2. Prescribed costs on the sum of $21,000.00 to be paid by the claimants to the defendant in the sum of $3,150.00.

Kimberly Cenac-Phulgence
High Court Judge

By the Court

Registrar